Montana's Workers' Compensation System . . .

Declaration of Public Policy

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Declaration of Public Policy[1]

It is an objective of the Montana workers' compensation system to provide, without regard to fault, wage supplement and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole; they are intended to assist the injured worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

A worker's removal from the work force due to a work-related injury or disease has a negative impact on the injured worker, the injured worker's family, the employer, and the general public. Therefore, the main objective of the workers' compensation system is to return injured workers to work as soon as possible after suffering a work-related injury or disease.

Montana's workers' compensation and occupational disease insurance systems are intended to be primarily self-administering. Claimants should be able to obtain benefits speedily and employers should be able to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

Title 39, chapters 71 and 72 (Workers' Compensation Act and the Occupational Disease Act), must be construed according to their terms and not liberally in favor of any party.

The legislature's intent regarding stress claims, often referred to as "mental-mental claims" and "mental-physical claims", does not allow for compensation under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to verify objectively and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, injuries such as repetitive injury claims are not compensable under the present system. The legislature has the authority to define the limits of the workers' compensation and occupational disease system.

[1] §39-71-105, MCA

Insurance - Who's Covered, Who's Not

If you are an employer or an employee, the Workers' Compensation Act applies to you. An employer who has an employee in service under any appointment or contract of hire, expressed or implied, oral or written, must elect to be bound by the provisions of compensation Plan 1 (self-insured), Plan 2 (privately insured), or Plan 3 (State Fund).

Employment Exempted[2]

The Workers' Compensation Act and the Occupational Disease Act do not apply to any of the following employments:

- Household and domestic employment
- Casual employment
- Dependent member of an employer's family for whom an exemption may be claimed by the employer under the federal Internal Revenue Code
- Sole proprietors, working members of a partnership, working members of a limited liability partnership, or working members of a member-managed limited liability company
- Real estate, securities or insurance salesperson paid solely by commission without a guarantee of minimum earnings
- A direct seller
- Employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States
- A person performing services in return for aid or sustenance only
- Person performing services in return for aid or sustenance only, except employment of volunteers
- Employment with a railroad engaged in interstate commerce
- An official, including a timer, referee, or judge, at a school amateur athletic event
- A person performing services as a newspaper carrier or freelance correspondent
- Cosmetologist's services and barber's services
- A person who is employed by an enrolled tribal member or an association, business, corporation, or other entity that is at least 51% owned by an enrolled tribal member or members, whose business is conducted solely within the reservation
- A jockey who is performing under a license issued by the Board of Horse Racing, from the time the jockey reports to the scale room prior to a race through the time weighed out and has acknowledged in writing that jockey is not covered while performing services as a jockey
- Trainer, assistant trainer, exercise person, or pony person who is providing services under the Board of Horseracing while on the grounds of a licensed race meet
- An employer's spouse
- A petroleum land professional
- An officer of a quasi-public or a private corporation or manager of a manager-managed limited liability company
- A person who is an officer or a manager of a ditch company
- Service performed by an ordained, commissioned, or licensed minister of a church
- Independent Contractors

[2] §39-71-401,MCA

Life of a Claim

Accidents do happen and when a Montana worker files a workers' compensation claim, the life of that claim is dictated primarily by statute. Progress of a typical workers' compensation claim in Montana is determined by the following guidelines:

- Once the injury occurs, the injured worker or their authorized representative has 30 days from the date of injury to notify the employer (employer, managing agent or superintendent in charge of the work) or the insurer. [§39-71-603, MCA]
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- The employer then has six days from date of notification of an injury to report the injury to the insurer or the Department of Labor and Industry. [§39-71-307, MCA, and ARM 24.29.801]

- The claimant or the claimant's representative has 12 months from the date of injury to file a claim. [§39-71-601(1), MCA] The claim filing time can be extended up to an additional two years if it can be proven that the worker was somehow prevented from filing the claim because of something the employer said or did, or if the injury was latent or the worker lacked knowledge of disability. [§39-71-601(2), MCA]

- The signed claim form or First Report of Injury (FROI) (form ERD-991) can be submitted to the employer or sent directly to the insurer, the adjuster or the Department of Labor and Industry. [§39-71-601(1), MCA]

- The insurer/adjuster determines compensability based on descriptions of the accident provided by the employee and employer, and the time, place and circumstances of injury. This must be done within 30 days from date of receipt of the First Report of Injury. [§39-71-606, MCA]

- If further investigation is needed before the insurer accepts liability and the 30 day limitation for a decision on compensability is due to expire, the insurer/adjuster might pay wage loss and/or medical benefits without such payment being an indication of admission of liability or waiver of any right of defense. [§§39-71-608 and 39-71-615 MCA]

- The first 5 days or 40 hours (whichever is less) of total wage loss is not compensable but a claimant may use sick leave or vacation leave during this time. They cannot use sick leave and receive wage loss benefits at the same time. [§39-71-736, MCA]

- In addition to using an emergency room or urgent care center, the claimant has the right to select the first treating physician but the insurer must then approve changes of treating physicians. The insurer has the right to deny payment for any unauthorized medical referrals and treatments. [§39-71-1101, MCA, and ARM 24.29.1510]

- The physician bills the insurer/adjuster directly. Payment is made according to a fee schedule. [§39-71-704(2) and (3), MCA] The claimant is not responsible for any unpaid balance. Some insurers require that after the initial visit the claimant pay a co-payment of 20%, not to exceed $10, for a visit to a medical service provider, or $25 for an emergency room visit. [§39-71-704(7), MCA] The claimant is responsible for payment of any unauthorized treatment and for conditions not related to the industrial injury. [ARM 24.29.1401]

- Temporary total disability (TTD) benefits are based on 66 ⅔% of the claimant's average gross wages subject to a maximum of the state's average weekly wage, and are paid bi-weekly until the claimant returns to work or has reached maximum medical improvement (MMI). [§§39-71-701 and 39-71-740, MCA] If the claimant is classified as permanently totally disabled (PTD), benefits can continue until they reach retirement age. [§39-71-710, MCA]

- If, prior to attaining maximum medical improvement and due to medical restrictions, the claimant returns to work at less than the wages received at the time of injury, they may be entitled to temporary partial disability (TPD) benefits to make up the difference. Temporary partial disability is limited to 26 weeks unless extended by the insurer/adjuster. [§39-71-712, MCA]

- If, after reaching maximum medical improvement, the claimant has a residual impairment, greater than zero, which is a percentage of medical impairment to the whole body, the insurer/adjuster is required to pay out the permanent partial disability (PPD) liability bi-weekly, unless the claimant requests a lump sum. All unaccrued lump sum payments must be approved by the Department of Labor and Industry. [§§39-71-703 and 39-71-741, MCA]

- Other future permanent partial disability liability is typically based on age, education, loss of earning capacity, and work capacity restrictions. [§39-71-703, MCA]

- If the worker is precluded from returning to the joy they held at the time of injury and is suffering an actual wage loss or has an impairment of at least 15%, they are eligible for rehabilitation services. The insurer/adjuster selects a rehabilitation provider and a rehabilitation plan is established with the goal of returning the claimant to work as soon as possible. During retraining, the claimant may be eligible to receive monies from a trust fund for tuition, fees, books and other reasonable and necessary retraining expenses. They may also receive biweekly benefit payments based on their temporary total disability rate. [§39-71-1006, MCA] Financial assistance is also available for reasonable travel and relocation for training and job-related expenses. [§39-71-1025, MCA]

- Unless medical benefits are closed as a condition of settlement, they may remain available for at least 60 months (5 years) from the last date of service. The insurer may not be required to furnish palliative or maintenance care after the claimant has achieved maximum medical improvement.[§39-71-704(1)(e), MCA]

How is Montana's Workers' Compensation System Administered?

The Employment Relations Division provides a wide variety of services and regulation related to workers' compensation and safety.

Workers' Compensation Regulation Bureau

The **Contractor Registration Unit** ensures businesses have complied with workers' compensation requirements. The law provides protection from liability for workers' compensation claims for contractors who use the service of other registered construction contractors.

The **Uninsured Employers Fund Unit** ensures employers and employees are protected under the Workers' Compensation and Occupational Disease Acts. The Unit enforces coverage requirements for all employers, pays benefits to injured workers whose employers did not have workers' compensation coverage, and manages the fund from which benefits are paid.

The **Subsequent Injury Fund Unit** administers the funds that are used to offset claim costs associated with injuries to workers with disabilities. This reduces claim liability and provides an incentive for employers to hire certified workers.

The **Medical Regulations Unit** administers a program that provides an effective and equitable method of health care cost containment. Medical fee schedules are established by the unit and utilized by insurers to reimburse medical providers.

The **Carrier Compliance Unit** monitors compliance of private workers' compensation carriers. The unit also licenses professional employer organizations and processes extraterritorial agreements.

The **Independent Contractor Central Unit** issues decisions on employment relationships for the Department of Revenue, Labor Standards, Unemployment Insurance, and Workers' Compensation Compliance. The unit also issues Independent Contractor (IC) Exemptions.

Claims Assistance Bureau

The **Claims Unit** ensures compliance with the workers' compensation and occupational disease laws relating to benefits and claims. The unit also regulates attorney fees, administers the occupational disease panel process, and provides assistance to insurers, attorneys, and injured workers.

The **Data Management Unit** enters data on new claims, receives data on new claims through electronic data interchange (EDI), tracks policy coverage, maintains the workers' compensation database system, and provides a comprehensive annual report on workers' compensation to the governor and the legislature.

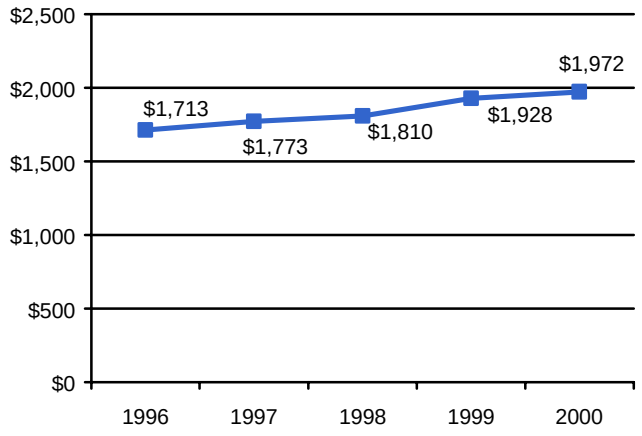
The **Mediation Unit** provides an alternative method of resolving workers' compensation benefit disputes before the dispute goes to the Workers' Compensation Court. This is a mandatory non-binding process.

Occupational Safety & Health Bureau

The **Occupational Safety & Health Bureau** conducts inspections of public employers, performs on-site consultations for private employers, and inspects coal mines and sand and gravel operations throughout the state. The Bureau provides safety and occupational health training for both public and private employers.

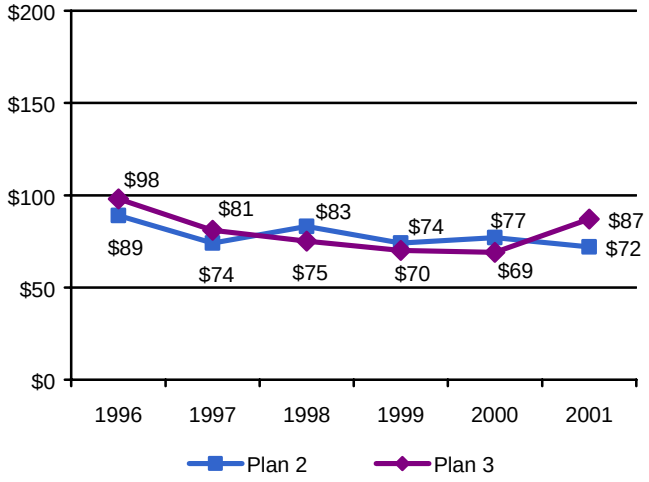
Montana Workers' Compensation Market

Gross Annual Payroll
Plan 1 - by Calendar Year



Notes:
Plan 1 employers pay no premium.
Calendar year 2001 data was not available at the time this report was published.

Premium Dollars
Plan 2 & 3 - By Calendar Year



Montana employers have several options for obtaining workers' compensation coverage for their employees.

Employers with sufficient cash reserves may qualify as self-insured (Plan 1), either individually or by joining with other employers in their industry to form a self-insured group. Montana currently has 43 individual self-insured employers, four private groups (119 employers), and four public groups (371 employers).

Employers who do not self-insure have two options:

- They may obtain coverage with private insurance companies (Plan 2) in the voluntary market. 410 private insurance companies were authorized to write workers' compensation insurance in Montana in calendar year 2001.
- They can insure through Montana's State Fund (Plan 3). As the insurer of last resort, the State Fund assures all Montana employers can provide workers' compensation insurance for their employees.

The change in the Plan 1 and insurer's market share is reflected in the table below.

Distribution of Market Share
by Plan & by Calendar Year

Calendar Year	1996	1997	1998	1999	2000	2001
Plan 1 – Payroll	$1,713,291,665	$1,773,148,488	$1,810,313,984	$1,927,960,055	$1,971,770,980	*NA
Plan 2 – Premium	$89,893,661	$74,615,961	$83,274,441	$74,142,380	$77,129,965	$72,431,388
Plan 3 – Premium	$98,270,000	$81,057,000	$75,177,196	$70,422,976	$69,411,843	$86,813,640

Notes:
*Calendar year 2001 Gross Annual Payroll data was not available when this report was published.

*Significant Court Cases From 2001**

DEBRA STAVENJORD vs STATE COMPENSATION INSURANCE FUND

2001 MTWCC 25

Summary: Claimant urges that the failure of the Occupational Disease Act (ODA) to provide permanent partial disability (PPD) benefits equivalent to those available under the Workers' Compensation Act (WCA) violates her equal protection rights. If her claim arose under the WCA she would be entitled to $27,027 in PPD benefits, § 39-71-703, MCA, whereas under the ODA the maximum she can recover is $10,000. § 39-72-405, MCA (1997).
Held: Under *Henry v. State Compensation Insurance Fund,* 1999 MT 126, the $10,000 limitation is unconstitutional and claimant is entitled to the same benefits she would receive if her condition arose under the WCA.
Note: Decisions have been stayed pending appeal to the Supreme Court.

CASSANDRA SCHMILL vs LIBERTY NORTHWEST INSURANCE CORP

2001 MTWCC 36

Summary: Claimant suffers from an occupational disease. Even though the Occupational Disease Act (ODA) makes no provision for impairment awards, she filed a petition alleging that she is entitled to one. Following this Court's decision in *Stavenjord v. State Compensation Ins. Fund,* 2001 MTWCC 25, which held that claimants suffering from occupational diseases are entitled to at least the same permanent partial disability benefits available to workers suffering industrial injuries, the insurer conceded liability for the impairment award but, relying on the apportionment provision of the ODA, § 39-72-706, MCA (1989-1999), reduced the award by 20% due to the 20% contribution of non-occupational factors to the claimant's condition.
Held: The apportionment provision of the ODA, § 39-72-706, MCA (1989-1999), violates the Equal Protection Clauses of the United States and Montana Constitutions. Therefore, claimants under the ODA are entitled to full benefits without any reduction based upon the contribution of non-occupational factors. Attorney fees and a penalty are denied since the insurer was entitled to rely on the presumption that the provisions of the ODA are constitutional.
Note: Decisions have been stayed pending appeal to the Supreme Court.

RICHARD FLIEHLER vs UNINSURED EMPLOYERS' FUND

2001 MTWCC 29

Summary of Case: Claimant was hired in Montana to help install kitchens for restaurants located out of state. His employer resided in Montana, received plans for jobs while in Montana, kept his equipment and truck in Montana, hired his workers in Montana, designated all out-of-

*Case summaries are taken from the Workers' Compensation Court web site: http://wcc.dli.state.mt.us.

state jobs on which this claimant was employed from Montana, paid claimant in Montana on a Montana bank account, and transported his workers from Montana to jobs, then back to Montana after completing most jobs.
Held: (1) Claimant was an employee since he was not engaged in an independent business. (2) Although he was injured in Oklahoma on an Oklahoma job, he was a resident of Montana and his work was controlled from Montana, therefore his injury is subject to the Montana Workers' Compensation Act. (3) Since his employer was uninsured, the Montana Uninsured Employers' Fund is liable for benefits.

ALBERTA BLACK vs MDMC/BENEFIS HEALTHCARE

2001 MTWCC 47

Summary: Claimant was 64 years of age when she was injured at work. She returned to a modified job but that job was then eliminated. By that time she was 65. She has been paid an impairment award but has been denied other permanent partial disability benefits based on § 39-71-710, MCA (1997), which provides that workers taking early social security retirement or who are eligible for full social security retirement or equivalent benefits are ineligible for permanent partial disability benefits other than the impairment award. Claimant challenges the constitutionality of the provision on equal protection grounds.
Held: Statute which denies permanent partial disability benefits to injured workers who have taken social security retirement or who are eligible for full social security retirement or equivalent benefits does not violate the Equal Protection Clause of either the Montana or United States Constitution.

EULA MAE HIETT vs MONTANA SCHOOL GROUPS INSURANCE AUTHORITY

2001 MTWCC 52

Summary: Montana Schools Group Insurance Authority (MSGIA) accepted liability for school custodian's back injury and paid disability and medical benefits. When claimant reached MMI, she was restricted to sedentary to light-duty work. MSGIA and claimant settled her claim for indemnity benefits with the proviso: "Further medical and hospital benefits are reserved by the claimant." At the time of the settlement, MSGIA was paying for claimant's injury-related medications. Subsequently, a new adjuster on the file determined that claimant was not working and was not entitled to payment for her medications. The adjuster relied on § 39-71-704(1)(b), MCA (1995), which provides that the insurer shall furnish secondary medical services "only upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment." The insurer argued that claimant has already reached MMI, so the prescriptions are not primary medical services under § 39-71-704(1)(a), MCA (1995), and that coverage under subsection 1(b) is not mandated where claimant is not working. Claimant is in fact receiving Social Security Disability benefits and there is no showing she is diligently seeking work. Claimant argues: (1) the settlement agreement, executed at a time when the insurer was paying for prescriptions, requires continued coverage; (2) prescriptions should be covered in order to maintain claimant's "medical stability"; and (3) the insurer should be estopped from denying coverage.

Held: The settlement agreement, by reserving medical benefits, did nothing more than reserve to claimant those medical benefits to which she is entitled under § 39-71-704, MCA (1995). Claimant's entitlement to c overage of the prescriptions, if such exists, must arise under the provisions of that section. The statutes regarding medical services are, unfortunately, poorly written and raise difficult questions of statutory interpretation. Under the statutes as written, prescriptions after claimant has reached MMI are not "primary medical services" because the…term primary medical services is defined in § 39-71-116(25), MCA (1995), as "treatment … necessary for *achieving* medical stability." (Emphasis added.) Coverage does not arise under the secondary medical services provision, subsection (1)(b), because secondary medical services are compensable only upon a demonstration of cost-effectiveness in returning claimant to actual employment and claimant has not satisfied that requirement. While this reading may render some statutory provisions meaningless, the Court is forced to choose between inserting language into the statutes which is not present, or construing some provisions as meaningless. It must choose the latter. Finally, the insurer is not estopped from prospectively refusing coverage of prescriptions where claimant has not demonstrated any detriment.
Note: The Hiett decision has been appealed to the Supreme Court.

SCOTT GRINER vs SENTRY INSURANCE MUTUAL COMPANY

2001 MTWCC 58

Summary: Claimant suffered a work-related, right-sided L5-S1 herniated disk in 1995. He underwent a microdiskectomy, reached maximum medical healing (MMI) following the surgery, and returned to work in March 1996. In January 1998 he was diagnosed as suffering from a left-sided L4-5 herniated disk. Amelioratory surgery was performed but as of May 18, 2000, he had not reached MMI with respect to the surgery. His surgeon, who treated and operated on him for both herniations, opined that the L4-5 herniated disk was a new condition caused by claimant's post-1995 work, especially heavy lifting. The surgeon and another physician who treated claimant for two months in early 1998 acknowledged that the 1995 injury predisposed claimant to further injury. The 1998 insurer alleges that the 1995 insurer is liable for the condition.
Held: The 1998 insurer is liable. The L4-5 herniated disk was a new condition and was not caused by the 1995 injury or condition. The fact that the 1995 injury may have in some way predisposed claimant to a subsequent injury does not constitute proof that it caused the subsequent injury or condition.

LIBERTY NORTHWEST INSURANCE CORPORATION vs STATE COMPENSATION INSURANCE FUND (ROBERT WAURIO)

2001 MTWCC 56

Summary: Claimant suffered a herniated disk in a February 2000 work-related accident for which the State Fund was responsible. He underwent back surgery, recovered to the point that he had minimal symptoms, and was determined to be at maximum medical improvement on September 1, 2000. On September 7, 2000, he began driving a heavy coal truck for his employer. Over the next two and a half days he experienced increasing pain and had to stop driving. A new MRI disclosed a reherniation of his disk and he has since undergone two additional back surgeries. In September, Liberty was the responsible insurer. It has paid benefits

but brought the present action for indemnification from the State Fund, alleging that the claimant's reherniation was caused by his original, February 2000 injury.
Held: Uncontradicted medical evidence establishes that claimant's truck driving in September 2000 caused the reherniation and that the reherniation would not have occurred had claimant continued working in the light-duty job he was doing for the several month period prior to the truck driving. Under principles laid out in *Belton v. Carlson Transport* and *Caekaert v. State Compensation Mut. Ins. Fund,* Liberty is liable for claimant's resulting medical expenses and compensation benefits.

TONETTE ROMERO vs LIBERTY MUTUAL FIRE INSURANCE COMPANY and STATE COMPENSATION INSURANCE FUND

2001 MTWCC 5

Summary: Claimant injured her right arm in a 1992 industrial accident, and ultimately developed into thoracic outlet syndrome. Thereafter, she began experiencing left arm and hand pain and numbness, which her treating physician attributes to overuse of her left arm due to her inability to fully use her right arm. She developed symptoms prior to her returning to any work and has been diagnosed as suffering from thoracic outlet syndrome affecting her left arm. Claimant's physician testified that any activities requiring use of her arms causes claimant to overuse her left arm and causes her left arm to deteriorate. In November 1997 claimant went to work in the bakery at County Market in Billings. After 15 weeks her physician took her off work because of problems with both arms. Thereafter, she filed an occupational disease claim with respect to her left arm and her work at County Market. When the claim was denied she filed a petition with the Court. The first insurer (for the right arm) was joined. [**Note:** The Supreme Court affirmed the WCC decision in Romero v. Liberty Mutual Fire Ins. Co., 2001 MT 303N (a non-citable decision)].
Held: Claimant's left arm condition is a natural progression of her 1992 industrial injury and the insurer for the 1992 injury is responsible for it. The only physician who addressed the proximate cause criteria of the occupational disease act, § 39-72-408, found that the criteria were not met. While claimant's treating physician did not address the criteria, his testimony supports that determination as it establishes that any sort of activity requiring claimant to use her arms causes deterioration of her left arm condition.